PULMONARY FUNCTION TESTING

13291 Yonge Street, Suite 301
Richmond Hill, ON L4E 4L6
Phone: 905-773-6861 Fax: 905-773-2161

Patient Name: _____
FIRST NAME LAST NAME

OHIP/VC: _____ **DOB:** _____

Phone Number: _____ **Appointment Date/Time:** _____

Tests Required: (Please check all that apply)	**Additional Tests:** (Please check all that apply)
____ Spirometry ____ Flow - Volume Loop ____ Airway Resistance ____ Lung Volumes ____ Diffusing Capacity ____ Maximum Inspiratory and Expiratory Pressures (MIP/MEP) ____ Pre and Post Spirometry ____ Pre and Post Flow Volume Loop ____ Pulse Oximetry ____ **ALL OF THE ABOVE**	____ Exercise Oximetry – Six Minute Walk Test ____ Methacholine Challenge Testing

THIRD PARTY BILLING:
Please indicate below if a third party has requested testing:
__ WSIB __ Employer __ Insurance __ Patient

Billing Information: _____
(Please include contact info – name, billing address, phone and fax)

CLINICAL INFORMATION:
Reason for Testing:
_____

Recent Hemoglobin level:_____ gm/dL Date hemoglobin level taken:_____

PHYSICIAN INFORMATION:

_____ _____
Physician Name (please print) Physician Signature

Phone: _____ Fax: _____

ADDITIONAL COPIES TO:

_____